Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Trenton D. Weeks, DC

Respondent Name
American Zurich Insurance Company

MFDR Tracking Number
M4-13-0390-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 5, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I performed an evaluation to determine maximum medical improvement and impairment of the … claimant. I performed this examination at the request of the injured employee and the treating doctor.

Carrier EOR indicates code: NONE, carrier has not responded with review or payment of this billed examination.

Response: This examination was performed for the purpose of determining MMI and Impairment as it related to the work injury of 03/18/2011.
This billed examination has been outstanding since 10/14/2011 without any response from carrier/adjuster. This is a request for Medical Fee Dispute Resolution as so not to exceed the time limit allocated to doing so. This examination and report in no way constitutes treatment and was referred by the treating doctor. This report and bill was performed according to TDWC rules and should be paid in full.

10/18/2011: Billed examination was sent and confirmed via electronically.
10/19/2011: Billed examination was also sent via fax.
05/08/2012: Request for Bill Status/EOR for DOS 10/14/2011
Sent and confirmed via fax. 05/08/2012
08/13/2012: 2nd Request for Bill Status/EOR for DOS 10/11/2011
Sent and confirmed via fax. 08/16/2012

This bill should be paid in accordance with the adopted Medicare fee guidelines Texas Administrative Code

§134.204. Medical Fee Guideline."

Amount in Dispute: $650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier records do not show receipt of this bill form Requestor. Carrier asserts that Requestor has not previously submitted its bill for review and has not met the requirements for medical dispute resolution. This matter should be dismissed pursuant to 28 133.307(e)(3)(C)."

Response Submitted by: Flahive, Ogden & Latson, Post Office Drawer 201320, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 14, 2011	99456	$650.00	$650.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.10 and §133.20 set out the procedures for submission of medical bills by health care providers.
3. 28 Texas Administrative Code §134.204 (j) defines the medical fee guideline for reimbursement of examinations to determine maximum medical improvement and impairment rating.
4. No Explanations of Benefits were submitted for this request.

Issues

1. Did the requestor submit a medical bill in accordance with 28 Texas Administrative Code §133.10 and §133.20?
2. What is the correct MAR for the requested services?
3. Is the requestor entitled to reimbursement?

Findings

1. The respondent stated that "Carrier records do not show receipt of this bill…" Review of the submitted documentation supports submission of medical billing with necessary reports to the correct insurance carrier in accordance with 28 Texas Administrative Code §133.10 and §133.20.
2. 28 Texas Administrative Code §134.204 (j)(3) states, "The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." Review of the submitted documentation finds that the requestor provided a determination of maximum medical improvement and was not the treating doctor. Therefore, the correct MAR for this examination is $350.00.

   Further, 28 Texas Administrative Code §134.204 (j)(4) states, "The following applies for billing and reimbursement of an IR evaluation. (C)(ii) The MAR for musculoskeletal body areas shall be as follows. (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area." Review of the submitted documentation finds that the requestor performed a full physical examination with range of motion to determine impairment rating. Therefore, the correct MAR for this examination is $300.00.
3. Review of the submitted documentation supports that the requestor is entitled to reimbursement of $650.00 for the disputed services.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $650.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $650.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	January 6, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.